Conclusions Most patients with staphylococcal infections can be treated with vancomycin, which also contributes to cost reduction. A Bayesian approach shows better pharmacodynamic results than conventional dosing, with a 90% of patients successfully treated in a real setting. No conflict of interest.

**Results**

Meier method) were calculated in both groups.

The best polytherapy is associated with a major risk of adverse events (ADEs) and with an increase of both mortality and morbidity.

**Materials and Methods**

Patients entering A.O ‘Gaetano Rummo’ of Benevento were monitored by a dedicated hospital pharmacist, over a period of twenty-four months, by collecting data concerning recorded ADEs and total value analysis (mono/polytherapy), the seriousness and the number of medications considered suspicious.

**Results**

Out of 253 reports made, 140 (55.3%) involved patients undergoing polytherapy compared to 113 attributable to monotherapy. More precisely, 108 ADEs were considered ‘serious’ and 55.5% of these (60 cases) were due to the polytherapy. Out of 48 serious cases imputable to the use of one drug, just 1 has ended with the death of the patient (anaphylactic shock by ceftriaxone), 1 endangered the patient’s life and for 16 of them it was remedied by prolonging hospitalisation. Out of 145 cases which were considered by the detector as ‘not serious’, 80 proved to have been associated with polytherapy while 60 were relative to 1 medicine.

Conclusions The multi-drug approach represents a significant factor which can cause the appearance of ADEs. To improve health care it is desirable that competent professional figures, such as the pharmacist, would more often employed in a departmental activity of pharmacovigilance in order to develop a prior information network on the risk of medicine interactions and the proper use of the medication. No conflict of interest.

**Conclusions**

Patients with CF have lower immunosuppressant blood levels than the control group. However, there were no significant differences in the incidence of AR, the development of RF or in overall survival after transplantation between the two groups.

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**Pharmacotherapy: pharmacokinetics and pharmacodynamics**

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Conclusions Optimization of the deployment of BCMA in the Geriatric units of Toulouse CHU allows us to plan the development of this practise over a large number of clinical departments at a later date.

No conflict of interest.

Materials and Methods The study period lasted from September 2011 to January 2012 (inclusive), in a 420-bed hospital. Every day, creatinine values over 130 mmol/l were filtered. Treatment was reviewed and we obtained creatinine clearance values (Crockcroft & Gault) of selected patients. After consulting the drug dose adjustment on the sheet and in Micromedex, a report was sent with the pharmaceutical recommendation.

Results There were 68 interventions for the 2147 patients studied: Internal Medicine (34) Cardiology (1), Short Stay Unit (5), Orthopaedics (7), Urology (5), Haematology (7) Surgery (5), Neurology (1), Intensive Care Unit (ICU) (2) Oncology (1). 55.9% of notifications were for changes in the dose of enoxaparin (38), 11.8% of amoxicillin-clavulanic acid (8), piperacillin-tazobactam 14.7% (10), 8.8% levofloxacin (6), 2.9% meropenem (2), 2.9% ciprofloxacin (2), 1.5% imipenem (1) and 1.5% aztreonam (1). The proportion of suggested changes accepted was 58.8% (40). 5.9% (4) discontinued treatment, 5.9% (4) were discharged and 29.4% (20) not changed. Of the latter, five were for changes in the pattern of enoxaparin in trauma patients, another 5 from Internal Medicine and 2 more from Haematology and ICU. The rest of them were changes in the pattern of antibiotics (imipenem 1, 2 levofloxacin, 1 meropenem, 1 ciprofloxacin, piperacillin-tazobactam 5) that were given out in the different services.

Conclusions A high percentage of doctors followed the recommendations. Part of the unaccepted tally corresponds to trauma patients whose prophylactic regimen of enoxaparin (40 mg/24 h) was not modified due to the service criteria. Some of the antibiotic prescriptions were not changed because of the severity of the patient’s illness (1 levofloxacin and 1 Internal Medicine Meropenem Imipenem Oncology and 1). The rest were rejected without explanation.

No conflict of interest.

Background Rilpivirine is a second-generation non-nucleoside reverse transcriptase inhibitor that is highly potent against both wild-type and drug-resistant HIV-1 strains. The quantification of rilpivirine in human plasma is important to support clinical studies.

Purpose Rilpivirine was just approved in May 2012 in Japan. Therefore, pharmacokinetic studies of rilpivirine have still not been completed in Japanese patients. We intended to develop a conventional method for determining plasma rilpivirine concentrations and compare plasma rilpivirine concentrations of Japanese HIV-1 infected patients with those of foreign healthy volunteers.

Materials and Methods We used a Waters Alliance 2695 HPLC and a Micromass ZQ-2000 MS, controlled with MassLynx version 4.0 software. Our method involves rapid liquid-liquid drug extraction from plasma and use of gradient elution on a reversed-phase C18 column. We recruited 34 Japanese HIV-1 infected patients who were treated with a rilpivirine-containing regimen at the National Hospital Organization Nagoya Medical Center, Japan. All patients had been given 75 mg rilpivirine once daily in combination with other antiretrovirals.

Results The LC-MS method established was validated by estimating the precision and accuracy for inter- and intraday analysis in the concentration range of 18–715 ng/ml. The calibration curve was linear in this range. Average accuracy ranged from 100.0 to 100.6%. Relative standard deviations of both inter- and intraday assays were less than 3.3%. In this study, mean rilpivirine plasma concentration at peak was 126 ng/ml (n = 18). Mean rilpivirine concentration at peak was 126 ng/ml (n = 6). These levels were higher than rilpivirine concentrations seen in trials with healthy foreign volunteers.

Conclusions Our LC-MS method provides a conventional, accurate and precise way of determining rilpivirine in human plasma. In clinical practise, AUC of rilpivirine for Japanese HIV-1 infected patients is larger in comparison with foreign data. We think that this was caused by the poor build of Japanese HIV-1 infected patients.

No conflict of interest.

Background In renal failure, alteration in the pharmacokinetics increases the frequency of overdoses.

Purpose To evaluate pharmaceutical care using a computer programme for drug dose adjustment in renal failure.

Materials and Methods The study period lasted from September 2011 to January 2012 (inclusive), in a 420-bed hospital. Every day, creatinine values over 130 mmol/l were filtered. Treatment was reviewed and we obtained creatinine clearance values (Crockcroft & Gault) of selected patients. After consulting the drug dose adjustment on the sheet and in Micromedex, a report was sent with the pharmaceutical recommendation.

Results There were 68 interventions for the 2147 patients studied: Internal Medicine (34) Cardiology (1), Short Stay Unit (5), Orthopaedics (7), Urology (5), Haematology (7) Surgery (5), Neurology (1), Intensive Care Unit (ICU) (2) Oncology (1). 55.9% of notifications were for changes in the dose of enoxaparin (38), 11.8% of amoxicillin-clavulanic acid (8), piperacillin-tazobactam 14.7% (10), 8.8% levofloxacin (6), 2.9% meropenem (2), 2.9% ciprofloxacin (2), 1.5% imipenem (1) and 1.5% aztreonam (1). The proportion of suggested changes accepted was 58.8% (40). 5.9% (4) discontinued treatment, 5.9% (4) were discharged and 29.4% (20) not changed. Of the latter, five were for changes in the pattern of enoxaparin in trauma patients, another 5 from Internal Medicine and 2 more from Haematology and ICU. The rest of them were changes in the pattern of antibiotics (imipenem 1, 2 levofloxacin, 1 meropenem, 1 ciprofloxacin, piperacillin-tazobactam 5) that were given out in the different services.

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